Communication in Acute Settings -

Useful Terms and Phrases

Good communication is not as simple as a recipe, however some language, phrases and terms have been found to cause less confusion and misunderstanding, or be helpful in establishing trust and rapport.

Establishing shared understanding

- Tell me about your/X's health over the last few months/years. *Pause, listen, then summarise all the health problems described, before asking:* how do you feel about that?
- What do you think might happen if your condition worsens? How do you feel about that?
- Please ask us anything you want to know. There is no such thing as you asking a silly question in these situations. We want you to help you to understand what is happening.

Treatments

- I want to think with you about the treatments we use here. They can save some people's lives, but they aren't the right treatment for everybody.
- I realise things must be very frightening and uncertain for you/for X just now. *(Pause – wait for comment/question)*
- In hospitals generally and intensive care specifically we perform treatments that are designed to save lives, If we reach a point that these treatments aren't working, then they can be quite cruel interventions (physically and psychologically)

General

- No matter how sick you get, and even if you are dying, we will always care for you/for X.

Poor prognosis -

- I'm so very sorry that X is/you are so sick that s/he/you could die.

Following their experience in Italy, The Italian Faculty of Palliative care made a "do's and don'ts" of phrases that they noted doctors used which caused discomfort or upset, and those which were more reassuring. These can be found here.

Community setting.

Patients who you think clinically would not benefit from ventilation may also benefit from having a conversation about whether a hospital admission would be appropriate or wanted:

"Should you deteriorate with this virus – which doesn't happen to most people and which we hope won't happen with you – it is useful to know whether you would want to be taken into hospital. There are currently no known treatments for Covid 19, and you would be unlikely to benefit from attempted ventilatio. If you would rather stay at home in the event of getting sicker, we need to put some plans in place. This will include having masks for your visitors, and providing medication to make sure you are comfortable and don't feel breathless at the end of your life."

In the context of hospital/ critical care

"We will do everything we can to help you get better. However, from what we understand about the course of this virus with your level of frailty/ comorbidities, there is a chance that you will get more unwell , and we will not be able to reverse the damage particularly to the lungs. If this happens, we will not attempt resuscitation or take you to Intensive Care as we believe there is very little chance it will help you. ."

Things are very uncertain. If X doesn't show some improvement over the next 2-3 days, then that would be a worrying sign that s/he may not be going to get better. (Pause – wait for comment/question) By that, I mean s/he may be sick enough to die.

The decisions we are making about holding back on unhelpful treatments are to cover the next (e.g. 24-48 hours.) We will keep on reviewing X, and if s/he shows signs of recovery, we can think again.

Although we are reducing treatments which do not appear to be working, we are not reducing care. We want to make X as comfortable as possible.

A lot of the things we do to save a patient's life can be unpleasant for the patient. We're very conscious that if we keep doing them to a dying patient, we could be committing a great indignity/unpleasantness towards them.